UNITED
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Secretariat

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23 December 1991

INFORMATION CIRCULAR

To: Members of the staff at duty stations away from Headquarters

From: The Controller

Subject: VAN BREDA MEDICAL, HOSPITAL AND DENTAL INSURANCE*

1. The purpose of the present circular is to set out the provisions concerning renewal of the Van Breda medical, hospital and dental insurance plan for staff members at offices away from Headquarters, which will take effect on 1 January 1992.

2. The plan incurred a modest deficit during the 1991 policy period. In addition, the average level of reimbursement per participant rose during 1991 reflecting increased levels of utilization and escalation in the costs of medical services world wide. As a result, the premiums for 1992 have had to be increased by approximately 15 per cent. This increase should be seen, however, against the background of the plan's performance over the last few years. In 1990 premiums remained the same as in 1989, and in 1991 premiums actually decreased by 5 per cent. The new premium rates are therefore only 10 per cent above the 1989-1990 level. Staff members are reminded that the Van Breda plan is "experience-rated", which means that premium levels, and thereby the monthly amounts paid by staff members as well as the related organizational subsidy, must be adjusted from policy period to policy period to ensure that total premium income is sufficient to meet the reimbursement expenses of the plan.

3. In addition to the 15 per cent premium increase, the key provisions of the renewal for 1992 are:

(a) A significant modification in the prior approval requirement for hospitalization in the United States of America (see paras. 6 and 7 below, and annex II);

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* Personnel Manual index No. 6190.

(b) Elimination of the requirement to obtain a second surgical opinion in respect of 16 surgical procedures listed in annex III (see para. 8 below and annex III);

(c) A clarification regarding the benefit for the treatment of alcohol and/or drug abuse (see para. 9 below, and annex I, para. 2 (e));

(d) A new benefit regarding testing for the HIV virus (see para. 10 below and annex I, para. 2 (h)).

4. The schedule of premiums which will become effective on 1 January 1992 as well as the related staff contribution rates are set out in the tables below:

Premium levels

	Monthly premiums (United States dollars)	
Type of coverage	Current	Effective 1 January 1992
Staff member only	61.00	71.00
Staff member and one family member	130.00	150.00
Staff member and two or more eligible family members	215.00	247.00

Staff contributions

	Percentages of medical net salary	
Type of coverage	Current	Effective 1 January 1992
Staff member only	1.04	1.18
Staff member and one family member	1.71	1.92
Staff member and two or more eligible family members	2.71	3.03

5. In line with the methodology used in the calculation of staff contributions towards premiums for other United Nations insurance schemes, the contributions of participants in the Van Breda scheme are calculated as a percentage of their respective medical net salaries in accordance with the rates set forth above. Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the premiums shown above.

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Prior approval for hospitalization in the United States

6. A substantial modification to the provision regarding prior approval for hospitalization in the United States is being introduced, on a trial basis, with effect from 1 January 1992. Formerly, when a "prior approval" request was submitted, Van Breda evaluated the request in accordance with a set of criteria which are outlined in annex II, paragraph 2, of circular ST/IC/1990/84. Under the new arrangement, the participant is obliged only to notify Van Breda of his or her intention to be hospitalized in the United States. However, if a participant fails to register a United States hospitalization with Van Breda prior to the admission, the normal reimbursement calculated will be reduced by 25 per cent and the major medical coverage component will not apply in respect of doctors' fees for services administered during hospitalization. As before, there will be no penalty in cases of medical evacuation to a United States hospital approved by the United Nations Medical Director, nor in cases of bona fide emergency.

7. The new procedure no longer entails any approval on the part of Van Breda. Van Breda must be informed in writing of the intended hospitalization in the United States at least two weeks prior to the admission. However, under the arrangement which will become effective on 1 January 1992, a "cap" of US$ 700 will apply to the daily semi-private hospital room rate. Thus, if a participant, in notifying Van Breda of a hospitalization in the United States in line with the procedure set out in paragraph 3 of annex II to this circular, chooses a hospital at which the daily semi-private room rate exceeds $700, the cost of the daily room rate above $700 will be borne entirely by the participant. There will be no change in the reimbursement for other services. The provisions pertaining to the revised United States hospitalization measure are set out in full in annex II to this circular.

Second surgical opinion

8. Previous circulars have indicated that a second surgical opinion had to be sought in connection with 16 surgical procedures, as set out in annex III of circular ST/IC/1990/84. With effect from 1 January 1992, a second surgical opinion will not be mandatory. Therefore, Van Breda will no longer implement a reimbursement penalty for failure to obtain a second surgical opinion. However, participants continue to be strongly encouraged to seek a second surgical opinion whenever it is possible to obtain such opinion from a qualified independent physician. Thus, while no longer a requirement, Van Breda will continue to reimburse at the rate of 100 per cent expenses incurred in obtaining second opinions regarding any of the 16 procedures listed in annex III to this circular.

Treatment for substance (alcohol/drug) abuse

9. The cost of treatment for substance (alcohol and/or drug) abuse is covered by the Van Breda plan, under certain conditions. The coverage includes in-patient treatment for detoxification and rehabilitation at a

facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers out-patient counselling for the purpose of diagnosis and treatment. The costs of out-patient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem.

Testing for the HIV virus

10. In April 1991, the Administrative Committee on Coordination (ACC) adopted a policy statement on personnel questions related to the HIV epidemic and the spread of AIDS. In the policy adopted by ACC, it is stated that "voluntary testing with pre- and post-counselling and assured confidentiality should be available to all United Nations staff members and their families". Up to now, the Van Breda plan has not routinely covered the cost of such testing. With effect from 1 January 1992, Van Breda will, under the basic component of the plan, reimburse the costs of two blood tests per year for the HIV virus.

Eligible family members

11. "Eligible family members" refers to a spouse and one or more eligible children or no spouse but two or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

Participants with dependants residing in the United States

12. It should be borne in mind that participants currently in the Van Breda scheme with dependants residing in the United States are encouraged to enrol in the Blue Cross/Aetna Major Medical insurance plan. This is especially important since medical expenses incurred in the United States must generally be paid immediately and reimbursement claimed from the insurance company. In the case of hospitalization, persons not covered by a United States insurance company are not admitted unless expenses are prepaid or guaranteed by Van Breda. Therefore, participants in this particular situation are requested to switch as soon as possible to the Blue Cross/Aetna Major Medical plan offered by the United Nations. Participants choosing to remain on the Van Breda plan will be required to conform to the pre-approval requirements and will be responsible for all payments and prepayments incurred. As the Blue Cross/Aetna Major Medical plan does not include dental coverage,

participants may also wish to subscribe to the (optional) Group Health Incorporated (GHI) dental plan.

Basis for claim reimbursement in United States dollars

13. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Up to 31 December 1989, reimbursement was based on the United Nations operational rate of exchange in effect on the date the claim was signed. Since 1 January 1990, REIMBURSEMENT IN UNITED STATES DOLLARS HAS BEEN BASED ON THE UNITED NATIONS OPERATIONAL RATE OF EXCHANGE IN EFFECT ON THE DATE THE MEDICAL AND DENTAL EXPENSES ARE INCURRED, AND, IN THE CASE OF HOSPITAL EXPENSES, ON THE DATE THE HOSPITAL BILL IS RENDERED.

14. Annex I to the present circular sets out a summary of the benefits payable under the Van Breda plan.

15. Annex II contains a recapitulation of the new provisions pertaining to hospitalization in the United States.

16. Annex III sets out relevant details concerning the 16 surgical procedures for which an optional second opinion will be fully reimbursed.

Conversion privilege

17. Participants who cease employment with the United Nations and who do not qualify for after-service health insurance benefits may arrange for medical coverage with Van Breda under an individual contract, provided that application is made within 31 days of termination of coverage under the plan. The conversion privilege, which is part of the United Nations group contract with Van Breda, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. THE CONVERSION PRIVILEGE, HOWEVER, DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Van Breda at the following address:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, BELGIUM

Telex No.: BREDCO B 31788
Fax No.: 00 323 271 02 47 (facsimile transmission)

Annex I

VAN BREDA INSURANCE SCHEME

1. The Van Breda insurance scheme provides for reimbursement of medical, hospital and dental treatment costs up to a maximum of $200,000 per insured participant per calendar year. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also be applied on the basis of a determination of reasonable and customary charges for the benefit at the place of treatment.

2. The scheme is subject to the following provisions and limitations:

(a) Under the basic component, reimbursement in respect of medical treatment prescribed by qualified doctors is limited to 80 per cent of the costs incurred, including doctors' fees. Under the major medical component, 80 per cent of the remaining unpaid costs is paid, subject to a co-payment of $200 per participant and $600 per family;

(b) The cost of hospital services (excluding doctors' fees) is reimbursed at the rate of 100 per cent of the costs involved, including such items as bed and board, general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care, i.e., two or more patients in the same room, except that, under the following circumstances, private-room care will be reimbursed in full:

(i) When the nature and gravity of the illness requires private-room care and such care is requested by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards.

Europe and North America are defined for this purpose as Europe, including Eastern Europe, Malta, Cyprus and Turkey (European portion), and Canada and the United States of America;

(c) The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $750 per insured participant per calendar year. The cost of dento-facial orthodontics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years;

(d) The cost of out-patient mental health treatment, including psychoanalysis, is normally reimbursable only if the patient is treated by a medical doctor engaged in the practice of psychiatry. However, upon referral by a psychiatrist or, in localities where a psychiatrist is not available, by a qualified physician, the services of a licensed psychologist or a licensed psychiatric social worker will be covered. The costs of psychiatric treatment in respect of insured participants is reimbursable at the rate of 50 per cent and to a maximum reimbursement of $500 for not more than 50 visits per insured person in any consecutive six-month period;

(e) The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers out-patient counselling for the purpose of diagnosis and treatment. The costs of out-patient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem;

(f) The cost of radiological treatment is reimbursable at the rate of 80 per cent only if the patient has been referred to the specialist by the doctor in attendance;

(g) The cost of hearing aids and optical lenses is covered, with the following limitations:

(i) Hearing aids. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $150 per apparatus, including the related examination, and a maximum of one apparatus per ear in any period of three years;

(ii) Optical lenses. Reimbursement at 80 per cent (only basic coverage, no major medical coverage) with a maximum of $25 per lens and a maximum of two lenses in any period of two years.

In order to be entitled to these benefits, a staff member or the participating family member will have to have been a participant in the Van Breda scheme for one year or more;

(h) The cost of two blood tests per year for the HIV virus.

3. The insurance scheme does not cover:

(a) Periodic preventive health examinations;

(b) Examination of the eyes for optical lenses (eyeglasses or contact lenses);

(c) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(d) Insured participants who are mobilized or who volunteer for military service in time of war;

(e) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(f) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(g) Spa cures, rejuvenation cures or cosmetic treatment (cosmetic surgery is covered, however, where it is necessary as the result of an accident for which coverage is provided);

(h) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(i) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded.

4. In respect of 16 surgical procedures listed in annex III to this circular, the cost of a second opinion will be reimbursed at 100 per cent and, should a participant desire a third opinion, the cost of that opinion will also be reimbursed at the rate of 100 per cent. No penalty will be assessed in cases in which surgery is performed without the benefit of a second opinion.

Annex II

PROVISIONS PERTAINING TO HOSPITALIZATION IN THE UNITED STATES

1. A prior approval measure was introduced on 1 March 1988 to control the frequency of hospitalization within the United States where overall costs frequently run far above the costs for comparable medical services in other countries. With effect from 1 January 1992, prior approval from Van Breda for hospitalization in the United States will no longer be required. Under a new arrangement which is being introduced on a trial basis, the participant is obliged only to notify Van Breda of his or her intention to be hospitalized in the United States. However, if a participant fails to register a United States hospitalization with Van Breda prior to the admission, the normal reimbursement calculated will be reduced by 25 per cent and the major medical coverage component will not apply in respect of doctors' fees for services administered during hospitalization.

2. The new procedure no longer entails any approval or denial on the part of Van Breda. However, Van Breda must be informed in writing of the intended hospitalization in the United States at least two weeks prior to the admission. While a participant is free to seek admission to a United States hospital following provision of the necessary notification to Van Breda, reimbursement for such hospitalization will be subject to a limit of $700 in respect of the daily semi-private room rate. Thus, if a participant, in notifying Van Breda of a hospitalization in the United States in line with the procedure set out in paragraph 3 below, chooses a hospital at which the daily semi-private room rate exceeds $700, the cost of the daily room rate above $700 will be borne entirely by the participant. There will be no change in the reimbursement for other services.

3. Notification of hospitalization in the United States should be submitted to:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, BELGIUM

Telex No.: BREDCO B 31788
Fax No.: 00 323 271 02 47 (facsimile transmission)

Such notification must be submitted to Van Breda prior to the United States hospital admission and must contain the following information:

(a) Name and duty station of the subscriber;

(b) Name of patient and a statement of the diagnosis from the attending physician;

(c) Identification of the hospital in the United States where the procedure/treatment will be performed;

(d) Daily semi-private room rate at the hospital in question.

4. As noted in paragraph 2 above, hospital expenses incurred in the United States (semi-private accommodation) will be reimbursed in full, subject to the $700 daily room-rate limit. In this connection, it should be noted that hospital costs vary considerably throughout the United States, and costs may exceed the $700 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C., where the costs may be much higher in certain hospitals.

5. The $700 limit will not apply to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

(b) In cases of bona fide medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $700. To avoid the obligation to meet daily room-rate expenses in excess of $700 in such cases, confirmation must be obtained from Van Breda prior to the hospital admission.

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Annex III

SECOND SURGICAL OPINION

1. With effect from 1 January 1992, participants are no longer required to obtain a second opinion prior to undergoing surgery. No reimbursement penalty will be assessed by Van Breda for failure to provide evidence of a second opinion in connection with any surgery. However, whenever feasible, participants are encouraged to seek a second surgical opinion, particularly for the 16 surgical procedures listed below. For this reason, Van Breda will continue to reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought, and will also be fully reimbursed. Please note that the second opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery.

2. The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:

	Procedure	Explanation
1.	Bunionectomy	Removal of bunions
2.	Cholecystectomy	Removal of gall bladder
3.	Dilation and curettage	Dilation of cervix and scraping of uterus
4.	Excision of cataracts	Removal of cataracts
5.	Haemorrhoidectomy	Removal of haemorrhoids
6.	Hernia (inguinal) repair	Repair of hernia in the groin
7.	Hysterectomy	Removal of uterus
8.	Knee surgery	Knee operation
9.	Laminectomy	Removal of part of spine
10.	Mastectomy: partial or complete	Partial or complete removal of breast tissue
11.	Prostatectomy	Removal of prostate
12.	Septo-rhinoplasty	Nose surgery for functional improvement
13.	Spinal fusion	Surgical welding of spine segments

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	Procedure	Explanation
14.	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15.	Varicose veins	Removal and tying of varicose veins
16.	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

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